Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

GEORGE R STURGEON
143 DEER TRL
SPRINGTOWN TX 76082

Respondent Name:
CITY OF FORT WORTH

Carrier's Austin Representative Box
Box Number 04

MFDR Tracking Number:
M4-11-1636-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position summary was not submitted with request for medical fee dispute resolution.

Amount in Dispute: $113.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a position summary or respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 9, 2010 August 17, 2010	Out-Of-Pocket expenses for CPT Codes 99212	$113.40	0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation out-of-pocket expenses for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - An Explanation of Benefits (EOB) was not submitted by either party.

Issues

1. Did the requestor submit receipts for out-of-pocket expenses to the Carrier in accordance with 28 Texas Administrative Code §133.270?
2. Did the requestor submit documentation to support the disputed out-of-pocket expenses were submitted to the Carrier in accordance with 28 Texas Administrative Code §133.307
3. Is the requestor entitled to reimbursement?

Findings

Pursuant to "28 Texas Administrative Code §133.270(a) An injured employee may request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury, unless the injured employee is liable for payment as specified in: (1) Insurance Code §1305.451, or (2) §134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee). (b) The injured employee's request for reimbursement shall be legible and shall include documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider." Review of the documentation submitted by the injured employee did not contain a receipt showing payment in the amount of $175.00 had been made to the healthcare provider.

Pursuant to "28 Texas Administrative Code §133.307(c)(3) An employee who has paid for health care may request medical fee dispute resolution of a refund or reimbursement request that has been denied. The employee's dispute request shall be sent to the MDR Section by mail service, personal delivery or facsimile and shall include: (A) the form DWC-60 table listing the specific disputed health care in the form and manner prescribed by the Division; (B) an explanation of the disputed amount that includes a description of the health care, why the disputed amount should be refunded or reimbursed, and how the submitted documentation supports the explanation for each disputed amount; (C) Proof of employee payment (including copies of receipts, provider billing statements, or similar documents); (D) a copy of the carrier's or health care provider's denial of reimbursement or refund relevant to the dispute, or, if no denial was received, convincing evidence of the employee's attempt to obtain reimbursement or refund from the carrier or health care provider. Review of the documentation submitted by the injured employee did not contain convincing evidence that the injured employee sought reimbursement from the Carrier prior to filing the request for medical fee dispute resolution

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	September 16, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).